900 PLAN COORDINATION

901 Overview

This chapter describes how the DES/DDD Support Coordinator arranges for and coordinates services, both within and external to DES/DDD, to meet the needs of eligible individuals as identified in the Individual Support Plan (ISP). For services funded by the DES/DDD, the chapter specifies prior authorization procedures, requirements for cost effectiveness studies, waiting list procedures, referral and placement procedures, Support Coordinator responsibilities for coordinating acute care services with the ALTCS health plan, requirements for obtaining services out-of-area, and discharge/transfer procedures. It also describes policies and procedures necessary to provide effective, coordinated services with other agencies and programs, such as Child Protective Services, Adult Protective Services, the Department of Education, AHCCCS and Children's Rehabilitative Services.

902 Responsibilities of the Plan Coordinator

The DES/DDD Support Coordinator is typically the plan coordinator. In an ICF/MR, the Qualified Cognitive Disability Professional (QMRP) is the plan coordinator. The responsibility of the plan coordinator is to assist individuals in accessing services by ensuring that services, activities, and objectives identified in the ISP are arranged for and implemented.

903 Use of Community Resources

Upon completion of the ISP, the Support Coordinator shall coordinate activities necessary for the provision of services identified through the ISP. The Support Coordinator shall begin this process by first examining the services or other assistance which may be provided through existing community resources or family members.

Most communities offer an array of services which may meet the needs of individuals with developmental disabilities and their families. The type and availability of services will vary from community to community. It is the Support Coordinator's responsibility to know and have available community resource information i.e., facility, name, phone number, address and contact, and to provide that information to individuals and their families when it appears these resources may benefit the individual/family. A 24-hour Community Information and Referral hotline is also available in Phoenix and Tucson. The Tucson hotline number

also accesses information relative to the southern region of Arizona. (See Appendix 100.A)

Services available from community resources can increase the amount of services an individual receives and may provide services that may not be available through DES/DDD.

In general, services through community resources may include:

a. advocacy;

b. child care;

c. adaptive and/or medical equipment;

d. food;

e. housing;

f. legal assistance;

g. recreation;

h. transportation; and

i. utility assistance.

904 Service Authorization

The delivery of a service to be funded by DES/DDD requires authorization of the service prior to delivery. Support Coordinators may authorize services in certain circumstances, however, some services may require authorization in addition to that of the Support Coordinator, such as physician prescribed services which require prior authorization by Managed Care Operations (MCO). Other services may require authorization by the Assistant Director (AD) or designee.

The specific prior authorization requirements for each service are indicated in the Service Provision Guidelines sections of Chapter 600.

904.1 Support Coordinator Authorization

Authorization by the DES/DDD Support Coordinator shall be documented by the Support Coordinator's signature on the Cover Sheet of the ISP.

For ALTCS eligible persons, the Support Coordinator shall authorize ALTCS funded long term care services only when the Assessment and ISP processes outlined in Chapters 700 and 800 determine the services to be medically necessary and cost effective. Services are cost effective when the total cost does not exceed 80% of the cost of an ICF/MR (See Section 905). Non-covered services and services to be provided to non-ALTCS eligible persons shall be authorized only when the same processes determine them to be developmentally necessary and cost effective.

For both ALTCS and non-ALTCS services, the Support Coordinator shall ensure, prior to authorization, that other potential resources for meeting the identified needs have been explored and are either not available or not sufficient to meet the documented need. The Support Coordinator shall also ensure that the service will be provided in accordance with the service definitions and parameters outlined for each service in Chapter 600.

To ensure newly eligible ALTCS individuals receive services within thirty (30) days of ALTCS eligibility, Support Coordinators shall follow the steps outlined below in authorizing services:

a. the Support Coordinator determines (with input from the individual being served as well as other appropriate persons) the individual's needs within 10 days of roster transmittal of a newly eligible individual, and on an ongoing basis with currently eligible individuals;

b. the Support Coordinator enters the needed service code and the need date into the ASSISTS at CA-13 upon completion of 904.1.a;

c. the Support Coordinator forwards information relative to the needed service, the amount of units, the start and end dates and the preferred provider to the District authorization staff for input into the ASSISTS;

d. the District authorization staff review the information and match provider/contract/budget (Funding) source and enter the authorization information into the ASSISTS at CA-08 and CA-08A;

e. the District authorization staff forward the completed authorization information to the provider and to the Support Coordinator; and

f. the Support Coordinator notifies the individual of the provider assignment upon completion of step 904.1.e and facilitates the referral process and initiation of service delivery.

904.2 Other District Authorization

Prior Authorization by the Support Coordination Supervisor or District Program Manager (DPM), when needed, shall be indicated by signature on the "Other Approvals if Needed" section of the ISP Cover Sheet (Appendix 800.A).

Supervisory and management staff shall authorize services in accordance with the policies and procedures outlined in Chapters 600, 700, 800, and Section 904.1.

Entry of authorizations on ASSISTS shall be completed following Support Coordinator authorization, other District management staff authorization, if needed, and MCO authorization, if needed.

904.3 Managed Care Authorization

Therapies above a certain level, Home Health Aide, Home Health Nurse, Hospice, Respiratory Therapy, Energy Assistance and Home Repairs/Environmental Modifications require prior authorization through MCO. Chapter 600 outlines specific procedures for each service.

904.4 AHCCCS Prior Authorization (ALTCS Eligible Individuals)

Certain services such as home repairs, environmental modifications, energy assistance or other services as approved by the Director of AHCCCS require prior authorization by the AHCCCS Administration. Such services must be reflected in the ISP, ordered by the primary care physician (PCP), authorized by the Support Coordinator and well documented as to the type of service, cost, name of the provider and justification for the service or item.

The Support Coordinator/individual/responsible person must obtain written estimates for the requested service. The Support Coordinator must complete the ALTCS Home Repair and Environmental Modification Request/Justification Form (Appendix 600.I) and forward it to the Medical Services Manager in MCO. The Medical Services Manager will review the request and, if appropriate, forward the request to AHCCCS.

The Medical Services Manager will notify the Support Coordinator when the request is submitted to AHCCCS and will forward a copy of the AHCCCS decision to the Support Coordinator. If approved, the Support Coordinator or individual/responsible person will pursue any approved repairs/modifications with the selected provider. Approvals or denials must be reflected in the ISP. If the request is denied by either the Medical Services Manager or AHCCCS, the Support Coordinator/District shall not authorize, approve or pay for repairs or modifications.

For individuals who require services which would exceed the cost of 100% of an ICF/MR, prior authorization must be obtained from AHCCCS for the services to continue at that level. Support Coordinators must justify the service plan and have a plan to lower costs over the next six (6) months.

905 Cost Effectiveness Studies

Written Cost Effectiveness Studies (CES, Appendix 600.D) are required by AHCCCS for ALTCS eligible persons under the following circumstances.

905.1 Ventilator Dependent

A cost effectiveness study shall be completed for all individuals in the Ventilator Dependent program. The Support Coordination Team (Support Coordinator and nurse) will complete the CES form and submit copies to MCO, Medical Services Manager and Business Operations, Fiscal Services Specialist. The Fiscal Services Specialist shall enter the information into CATS. (See Chapter 1400 for additional information)

905.2 ICF/MR Discharge

A cost effectiveness study shall be completed for any resident of an ICF/MR for whom discharge is contemplated. To meet this criteria, there must be a plan approved by the responsible person to place the individual in a setting outside the ICF/MR and a Discharge Plan in place consistent with Sections 809.5 and 910. The Support Coordinator shall complete the CES form and submit a copy to the DES/DDD Business Operations, Fiscal Services Specialist. The Fiscal Services Specialist shall enter the information into CATS for review by AHCCCS.

905.3 Services Exceeding 80% of ICF/MR Cost

A cost effectiveness study shall be completed for any individual whose ALTCS covered services exceed 80% of the average cost of an ICF/MR placement. A report indicating these individuals will be run quarterly from ASSISTS by the Business Operations Fiscal Services Specialist and routed to the MCO Medical Services Manager and District Long Term Care Program Representatives for distribution within each District. Within 30 days, the Support Coordinator shall review current services and potential changes and, in consultation with other appropriate District staff, complete the CES form projecting costs for the next 3 months. The Support Coordinator shall submit a copy of the CES to the MCO

Medical Services Manager and to the District ALTCS Specialist. MCO will submit the CES to Business Operations, Fiscal Services Specialist. The Fiscal Services Specialist shall enter the information into CATS.

The Support Coordinator shall also complete a plan to prospectively reduce the costs over the next 6 months. A copy of this plan shall be sent to MCO Medical Services Manager who shall forward the plan to AHCCCS.

905.4 Services Exceeding 100% of ICF/MR Cost

When an individual's service costs exceed 100% of ICF/MR costs (consult the DPM for current costs) with no decrease anticipated within 3 months, the Support Coordinator and District Nurse shall:

a. complete the CES form projecting the cost for the next 3 months;

b. meet with the individual/responsible person, discuss the costs and offer alternative services, e.g., HCBS under 100% or institutional services; and

c. if the individual/responsible person rejects the alternative services, the Support Coordinator shall provide the following information to MCO, Medical Services Manager:

   1. current diagnosis;

   2. date of meeting with family and their decision;

   3. copy of CES form;

   4. copy of recent PAS;

   5. copy of ISP;

   6. copy of IEP, if appropriate;

   7. pertinent medical information which substantiates need for services;

   8. ASSISTS Service Plan printout; and

   9. placement options.

MCO shall submit this information to AHCCCS for review. Any individual who exceeds 100% of ICF/MR costs must be approved by AHCCCS to continue to receive home and community based services. MCO will also submit the CES to the Business Operations Fiscal Services Specialist for entry into CATS.

906 Waiting List

906.1 Definition and Purpose

The Waiting List is the official, active register of persons needing the type, duration and/or intensity of services as described in the person's ISP, but who are unable to receive them due to funding limitations or unavailability of a provider.

The purpose of the Waiting List is to insure available resources are equally distributed to individuals and families statewide based upon prioritized needs as established below. Each District is allocated funding to address the needs of individuals eligible for services. DES/DDD is prohibited from exceeding the legislative appropriation.

A.R.S. § 36-552.C
A.R.S. § 36-557.D

906.2 Support Coordination Procedure

The Support Coordinator will complete the service evaluation process and make appropriate service referrals. When it has been determined the service is not available, it shall be deemed "waiting" and entered into ASSISTS (see Section 906.5 of this Manual). All service plan components shall be recorded, updated or terminated by the Support Coordinator in ASSISTS within five (5) working days of the initial, annual or review ISP.

All service plan components shall be assigned one (1) of four (4) dispositions of priority. Support Coordinators will consider the following principles when assigning a priority:

E. Emergency Need: Court ordered or Support Coordinator finds substantiated abuse or neglect as determined by Adult Protective Services (APS) or Child Protective Services (CPS) or a death in the family or a significant illness which would necessitate emergency placement;

I. Immediate Need: ALTCS services needed within thirty (30) days of the individual's enrollment in ALTCS or a family crisis where respite could prevent an out of home placement;

C. Current Need: ISP request for services which is unmet due to funding or provider availability; the need date is within twelve (12) months of initial entry; or

F. Future Need: ISP request for services which has a start date greater than twelve (12) months, but less than twenty-four (24) months from the date of initial entry on the Waiting List.

All Waiting List entries with priorities of "E" or "I" shall reflect service need dates (start dates) equal to or no greater than thirty (30) days from the referral date (date service is recorded on the ISP). Monthly reports will be generated including services with priorities of "C" or "F". District staff will review the reports and re-evaluate or re-prioritize the needs.

Waiting List entries older than 365 days and not associated with priority "F" shall automatically be purged from the system by Central Office.

906.3 District Management Procedure

It is the responsibility of the District management staff to assist Support Coordinators in identification and development of resources to meet individual needs. As resources become available, staff must award resources to individuals in accordance with the priorities noted in Section 906.2.

If the individual is ALTCS eligible, the District will authorize services consistent with the ISP.

If the individual is not ALTCS eligible, the District will:

a. establish whether the individual is eligible for any appropriated waiting list funds; and

b. establish whether the District has any other funds available for the provision of the services within their allocation.

Additionally, staff should follow these guidelines:

a. is the resource "fixed" or "movable"? A fixed asset is a service that can only be delivered in one system or area, such as a vacancy in a group home or day program. A movable asset is a service that can be adapted or transferred to meet the individual's needs;

b. which individual, within the District, has precedence to be removed from the Waiting List? Review priorities;

c. is the District able to meet the need? and

d. does the District have a resource which is not being utilized and may benefit a individual in another District?

906.4 ASSISTS Instructions

Support Coordinators will insure the following information is on the ASSISTS Waiting List Update screen:

a. individual's name, date of birth and ASSISTS identification number;

b. individual's service eligibility;

c. a description of the service needed (ASSISTS service code);

d. a description of the service priority (see Section 906.2 of this Manual);

e. the date the service is recorded on the ISP (referral date);

f. the requested start date of the needed service;

g. the status of the service:

C. change of provider;

F. funding not available;

P. provider not available; or

N. future need.

h. the date the service was closed from the Waiting List;

i. choice of service location; and

j. indicate if comment was provided on the Comment Screen.

The following information must be entered when completing the Waiting List Update Comment Screen:

a. service description;

b. service status;

c. referral date; and

d. comment (not to exceed one (1) screen line).

907 Referral and Placement

Following completion of all authorization procedures the Support Coordinator shall contact the identified provider and arrange to initiate the service.

Prior to the initiation of service, the Support Coordinator shall send a copy of the ISP to the identified provider.

Preschool aged children shall not be placed into a Child Developmental Foster Home which does not have a stay-at-home parent unless all other alternatives have been exhausted and the Assistant Director has given approval. All other alternatives include currently available Child Developmental Foster Homes. (See Chapter 1400) DES/DDD staff shall also make every attempt to develop an appropriate home if one is not available. The need for license expansion beyond the original number will be considered by the Assistant Director once the family's situation and family dynamics have been thoroughly explored. Licensing expansion will not occur unless it is determined that the child can fully benefit from this placement and that the quality of care and supervision of other clients who reside in the home will not be adversely affected.

For persons being placed in residential or day program service settings, the Support Coordinator shall also send to each provider the following information:

a. demographic information, to include client name, address, telephone number, date of entry into DES/DDD system, social security number, ASSISTS identification number; legal competency status; language spoken and understood; name of parent/responsible person/next of kin with address and telephone number; physician name, address and telephone number; and Third Party Liability information (company, policy number, etc.). Printouts of the appropriate ASSISTS screens and/or the ISP should contain most of this information and will be acceptable documentation for referral purposes;

b. current and appropriate consents and authorizations;

c. description of special needs and how these should be met, e.g., medical and behavioral, if not thoroughly documented on most recent ISP;

d. copy of most recent physical examination;

e. medical history, to include results of Hepatitis B screening, tuberculosis test results, and immunization records, if available;

f. current medications and medication history, if not thoroughly documented on most recent ISP; and

g. copies of other assessments necessary to provide effective services, such as vision and hearing screenings, dental records, therapy evaluations, psychological evaluations, etc.

In the event these records are not available, the Support Coordinator should assist the provider to schedule appointments or obtain the records needed to meet minimum residential licensing requirements.

Chapter 1400 outlines referral and placement procedures for clients being referred or placed with a Regional Behavioral Health Authority.

For people being placed in a NF or ICF/MR, a physician's order and the approval of the Assistant Director or designee shall accompany the above information.

The provider shall schedule a pre-placement meeting to meet the client, review the ISP and other records, and discuss any other information necessary to provide safe and effective services. The DES/DDD Support Coordinator shall attend pre-placement meetings for residential and day program settings. The DES/DDD Support Coordinator shall determine the need to attend pre-placement meetings for other home and community based services on a case by case basis.

908 Health Plans

DES/DDD as an ALTCS contractor is responsible to provide both acute medical services and long term care to ALTCS members who have a developmental disability. Acute medical services for ALTCS members are delivered through health plans or on a fee-for-service basis through MCO.

908.1 DES/DDD Support Coordinator Responsibilities

ALTCS eligibility may be determined prior to DES/DDD eligibility. In this instance, AHCCCS shall make a referral to DES/DDD for a potentially DES/DDD eligible individual. DES/DDD has 30 days from the date ALTCS sends the referral to make a DES/DDD eligibility determination and notify the Support Coordinator and the local ALTCS office of the outcome of the determination. Referrals are sent by the local ALTCS office to the appropriate DES/DDD office according to Zip Code.

It is very important that the Support Coordinator meet the time line. If it is not met the individual is automatically assigned to DES/DDD for the ALTCS program. DES/DDD becomes financially responsible and must provide services until a determination of DES/DDD eligibility is made and ALTCS is notified.

During intake or the ALTCS application process, the Support Coordinator must discuss health plan and PCP choices with the individual. It is important to stress that ALTCS eligibility is not guaranteed, but in the event of eligibility, the individual must choose the health plan and PCP quickly. See Chapter 400 for further information.

Native Americans living on a reservation can choose either Indian Health Services (IHS) or an available health plan. Those Native Americans who select IHS can receive authorization through DES/DDD for Medicaid covered services not available through IHS.

DES/DDD offers an annual ALTCS member open enrollment period. During this period, ALTCS members have the opportunity to change their health plan if a choice is available. MCO will coordinate the open enrollment process. MCO will provide training and health plan information related to the open enrollment process to Support Coordination personnel.

During open enrollment MCO shall advise members to call specific persons at each of the health plans for information, and to contact the Support Coordinator only if the member needs assistance in completing the health plan change request form.

Native Americans wishing to make a health plan change should be advised to contact their Support Coordinator who in turn shall contact the MCO Member Services Representative at Central Office to effect the change.

The delivery of ALTCS services varies slightly among the contracted ALTCS health plans. Support Coordinators shall first refer to the Health Plan Member Handbook and/or contact the health plan member representative for specific information on accessing services. If these resources are not available within a reasonable time frame to supply the necessary information, the Support Coordinator should contact MCO.

908.2 AHCCCS Responsibilities

Once determined eligible for ALTCS, the individual will receive a membership card from AHCCCS and will be enrolled in a health plan by DES/DDD or receive services on a fee-for-service basis through MCO.

908.3 Health Plan Responsibilities

Every ALTCS health plan sends a health plan member handbook to each of its members. The handbook explains the services that are covered, how to access them, and what to do when emergency services are needed. It outlines the member's responsibility to follow procedures. Health care providers may ask ALTCS members to make a minimal co-

payment for some covered services. Services cannot be denied if the member is unable to pay.

All services must be provided or approved by the PCP and received from the health plan provider network. A DD/ALTCS member who fails to follow procedures and receives services that are not approved or provided by a health plan contracted physician or other provider will be responsible to pay for those services.

DES/DDD, by contract with a health plan, may delegate some or all of its responsibility to that health plan for the following non-inclusive managed care responsibilities performed on behalf of ALTCS members enrolled with the health plan:

a. prior authorization of services and procedures as specified by the health plan;

b. claims processing according to policies and procedures defined by the health plan;

c. concurrent review, including certification and denial of inpatient hospital stay days, according to health plan procedures;

d. investigation and resolution of complaints and grievances according to policy and procedure specified by both AHCCCS and the health plan;

e. provider relations and member services activities;

f. financial monitoring and reporting as mandated under AHCCCS rules; and

g. all other quality assurance and utilization management activities as defined in the 42 CFR, AHCCCS rule, and health plan Quality Assurance/Utilization Review (QA/UR) Plan.

All such services/responsibilities must be in compliance with AHCCCS/ALTCS Rules and Regulations.

908.4 Comprehensive Medical and Dental Program (CMDP)

CMDP is mandated to provide medically necessary medical and dental services to children in foster care. Additionally, it is an ALTCS acute care health plan.

The CMD-025 Form (Appendix 900.A) is the basis of service provision by CMDP. The CMD-025 provides demographic information about the child and parents, insurance information and the type of action to be taken. The form is to be submitted, initially, within 72 hours of the dependency. Subsequent forms are to be submitted when a change is needed. The CMDP must receive the CMD-025 in order to determine if

a child is eligible for its health plan. The Support Coordinator shall submit a CMD-025 to the CMDP Eligibility Unit at site code 942C or FAX it to the number noted in Appendix 100.A (and if the child is ALTCS eligible, send a copy to the MCO Member Services Representative at 791A or the FAX number noted in Appendix 100.A) when a child:

a. comes into foster care;

b. changes custodial agency;

c. changes Support Coordinator;

d. voluntarily extends foster care past 18 years of age;

e. is in adoptive placement;

f. adoption becomes final - terminate CMDP;

g. is returned to his/her natural parent - terminate CMDP;

h. leaves foster care - terminate CMDP; or

i. dies - terminate CMDP.

The CMD-025 generates the foster child's CMDP identification number contained on the child's prescription drug card. This card will be sent from CMDP within 14 days of the submission of the CMD-025.

The Support Coordinator shall notify the CMDP Medical Review Unit when there is:

a. a change of address;

b. a change of PCP; or

c. a change in Support Coordinator.

The Support Coordinator shall notify the CMDP Eligibility Unit if a foster child is receiving SSI benefits by submitting either a memo or a copy of the SSI application upon receipt of notification of SSI eligibility.

MCO also works with CMDP for certain individuals receiving behavioral health services. Chapter 1400 outlines these processes.

909 Out of Area Service

ALTCS eligible individuals who need emergency medical services when out of their area of service may go to an emergency room. Emergency medical services are those services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient

severity (including severe pain) such that the absence of immediate attention could be expected to result in:

a. placing the patient's health in serious jeopardy;

b. serious impairment of bodily functions; or

c. serious dysfunction of any bodily organ or part.

Providers must notify the health plan within 12 hours of service provision. Non emergency services out of the area of service will not be covered.

A.A.C. R9-22-102; R9-22-210(B)

910 Case Transfer

910.1 Interdistrict Transfer

Comprehensive interdistrict transfer planning ensures continuity of an individual's services when the individual is moving from one District to another. Placements and services should be appropriate and established prior to an individual being transferred from one District to another.

The following procedures shall be implemented in cases of interdistrict transfer:

a. the originating DPM shall notify the receiving DPM of the impending transfer within 2 days of receipt of notification from the Support Coordinator, individual or responsible person;

b. a Support Coordinator will be assigned by the receiving District within 5 working days and the originating District Support Coordinator will be notified of the assignment;

c. the originating District's Support Coordinator will notify the local ALTCS office of the move, if the individual is ALTCS eligible on the Member Change Report (Appendix 900.B);

d. the originating District's Support Coordinator may meet with the receiving District's Support Coordinator to complete a transfer teaming and to transfer the individual's file;

e. staff from the originating District will meet with the Business Operations Director to discuss the transfer of funds to the receiving District; and

f. discharge planning procedures must be followed as appropriate (see Section 911).

910.2 Intradistrict Transfer

In order to ensure continuity of services when an individual changes Support Coordinators within a district, the sending Support Coordinator must document that the receiving Support Coordinator has been given a comprehensive understanding of the case. The case record must contain documentation of this process. At a minimum, the following information must be reviewed and documented with the receiving Support Coordinator:

a. the date and type of contact with the receiving Support Coordinator, i.e., telephone contact, person to person meeting, ISP meeting, etc.;

b. review of the individual's current ISP including the following:

1. services received and formal objectives;

2. services not received and the barriers to their receipt;

3. current medical condition, health plan or insurance information and medications;

4. status of pending health needs, i.e., durable medical equipment orders, scheduled surgeries, etc.; and

5. functional status;

c. individual and/or responsible person's notification of the change in Support Coordinator.

The documentation may be in the form of an ISP, progress note or a case transfer form.

911 Discharge Planning

Discharge planning is a systematic process for the transition of an individual from one health care setting to another or the transition of a medically involved individual from one residential placement to another. The key to successful discharge planning is communication between individual, family/caregiver and health care team. Depending upon the specific need of the individual, the following people may participate in the discharge planning process:

a. individual/family/caregiver;

b. Primary Care Physician (PCP)/Specialist;

c. Discharge Coordinator/Social Worker/Quality Assurance Nurse;

d. Utilization Review Nurse (hospital, DES/DDD or Health Plan);

e. DES/DDD Discharge Planning Coordinator;

f. DES/DDD Support Coordinator; and

g. other ISP team members, as necessary.

In order to ensure that Support Coordinators and District Nurses are aware of hospitalizations of ALTCS eligible individuals, the Managed Care Member Services Representative will SYSM the Support Coordinators and Nurse identified on ASSISTS when notified of an admission. It is the responsibility of the Support Coordinator to notify the DES/DDD District Nurse or Discharge Planning Coordinator of transfers of medically involved individuals or the hospitalization of a non-ALTCS eligible individual.

The discharge planning process is applicable in the health care setting as well as the transfer of a medically involved individual from one Child Developmental Foster Home (CDFH), Adult Developmental Home (ADH), Group Home, Intermediate Care Facility for the Mentally Retarded (ICF/MR) or Nursing Facility (NF) to another. The process will generally include the following activities:

a. DES/DDD Discharge Plan Assessment, e.g., nursing assessment;

b. review of discharge orders written by doctor;

c. ensure individual/family/caregiver has received proper training to carry out the discharge orders;

d. ensure that all necessary equipment and supplies have been ordered and will be available when needed;

e. ensure that transportation arrangements have been made;

f. reinstate applicable service(s) that may have been interrupted or initiate services now determined needed (update ISP);

g. a Hospital Utilization Review form will be completed by the DES/DDD Nurse or Discharge Planning Coordinator and copies sent to the Support Coordinator and MCO; and

h. notification and/or signatures as required on the Hospital Utilization Review form:

1. Managed Care Operations (MCO) Representative (District Nurse and/or Discharge Planning Coordinator);

2. DPM or designee (to be notified about all changes of placement);

3. Medical Director (to be notified by MCO of level of care changes); and

4. DES/DDD Assistant Director/designee (signature required for placement in ICF/MR).

911.1 Medically Involved Individuals

Comprehensive discharge planning for people who are medically involved ensures continuity of an individual's services when the individual is moving from one setting to another. Placement and services should be appropriate and established prior to the individual being discharged.

The Support Coordinator, District Nurse and/or the Discharge Planning Coordinator will work together to initiate the discharge planning process. Their communication can include an ISP. Convening an ISP team meeting is at the discretion of any team members.

The following procedures shall be implemented for all individuals who are medically involved:

a. the Nurse will verify hospitalization notification and/or transfer intentions with the Support Coordinator;

b. the District Nurse or Discharge Planning Coordinator shall follow the hospitalization and keep the Support Coordinator updated as to the individual's condition and concerns expressed by the individual/family/caregiver;

c. for those cases that are complex (medical, social and/or behavioral), an ISP team meeting should be called prior to discharge. The hospital discharge planner is considered lead and should assemble the family/caregiver, attending physician, PCP (if possible), social services, DES/DDD Support Coordinator and Nurse, Health Plan, Utilization Review (UR) nurse and other disciplines if their role would influence the discharge status/planning of the individual, i.e., Child Protective Services (CPS) or Adult Protective Services (APS);

d. if placement is an issue:

1. a nursing assessment will be updated/completed to assess the nursing/medical needs of the individual and identify the appropriate type of facility/residence;

2. if behavioral health is a need, referral to the Regional Behavioral Health Agency should be made by the Support Coordinator to initiate assessment and their participation in the discharge planning process; and

3. based on the ISP, the Support Coordinator will then work with the appropriate staff to arrange for the facility/residence which will provide for the identified needs.

e. if DES/DDD is expected to pay for an ICF/MR placement in part or in whole, a comprehensive review is required, including MCO, before any admission to the ICF/MR is made. All placements in ICFs/MR must have the approval of the Assistant Director. ICFs/MR are restrictive environments, therefore, placement is temporary and transitional, occurring only after the following alternative options have been eliminated:

1. in-home supports;

2. individually designed living arrangement;

3. community based placements, i.e., Group Home, CDFH or ADH.

(See Section 602.9 of this Manual for additional information on ICFs/MR.)

f. for those individuals who are returning to an ICF/MR, the DES/DDD District Nurse or Discharge Planning Coordinator shall participate in the planning process. The entire planning process shall be completed before the individual discharge/transfer is made;

g. in the absence of an ISP team meeting, the DES/DDD Nurse and/or Discharge Planning Coordinator will coordinate the discharge orders, caregiver training, equipment/supplies, home health care and transportation;

h. the DES/DDD Nurse or Discharge Planning Coordinator shall complete a Hospital Utilization Review form upon discharge and send copies to the Support Coordinator and MCO;

i. the Discharge Plan shall take precedence over any ISP objectives that are in conflict. If there is a conflict, a new ISP shall be developed as soon as possible. Disagreements shall be resolved by the individual/responsible person, PCP or any other attending physician involved. The medical records and a summary of the disagreement may be sent to the DES/DDD Discharge Planning Coordinator to be reviewed. The Office of Medical Director may be contacted to review the case and assist in the resolution of the disagreement; and

j. the individual's PCP shall be given the opportunity to participate in the discharge planning and review the completed ISP.

911.2 Nurse Consultation to Determine Medical Needs

The District Nurse or Discharge Planning Coordinator may be directly contacted by the Support Coordinator to review an individual's hospitalization or transfer plans to determine if medical discharge planning is needed. A Hospital Utilization Review form should be completed by the District Nurse or Discharge Planning Coordinator and submitted with appropriate documentation to MCO and the Support Coordinator indicating if skilled nursing needs have been identified.

911.3 Non-Medically Involved Individuals

For non-medically involved individuals who are being discharged from a hospital or NF, the following procedures shall be implemented:

a. the Support Coordinator shall assess for medical needs prior to discharge. If needed the District Nurse or Discharge Planning Coordinator will complete a nursing assessment to plan and recommend appropriate level of care;

b. if the individual is non-medically involved, the Support Coordinator will:

1. ensure that training of caregivers has taken place;

2. assess for and authorize in-home supports as appropriate;

3. make arrangements for equipment, supplies, medications, etc. through appropriate systems; and

4. ensure that follow up instructions are in place; and

c. in those situations where a residential setting will change, the ISP team shall be involved in the discharge planning process.

911.4 Foster Care Discharge Planning

The following discharge planning procedures shall be implemented for all individuals in foster care:

a. the Support Coordinator, District Nurse or Discharge Planning Coordinator will assess for medical needs prior to hospital discharge. If medical needs are present, the nurse will complete a Hospital Utilization Review form to coordinate plan of care, training, equipment and supply needs and a nursing assessment will be updated/completed to determine home based nursing services and/or placement needs;

b. the District Nurse or Discharge Planning Coordinator must be notified:

1. prior to any foster child being admitted to or discharged from an ICF/MR or NF; and

2. prior to any foster child that is medically involved and/or receiving home based nursing services or being considered for a change in placement, i.e., another CDFH, ICF/MR or group home; and

c. the ISP team must have a meeting or be notified by telephone prior to this change of placement. The District Nurse or Discharge Planning Coordinator will complete the Hospital Utilization Review form and coordinate plan of care, training, equipment and supply needs. The District Nurse or Discharge Planning Coordinator will notify MCO of change in placement and the Support Coordinator will notify the district. Specific to an ICF/MR admission, the personal authorization of the Assistant Director (or designee) is required.

912 Coordination With Other Programs and Agencies

912.1 Behavioral Health

When the ISP indicates a need for behavioral health services, the Support Coordinator shall initiate and coordinate the referral and delivery of such services with MCO Behavioral Health Unit staff. Refer to Section 1403 for policies and procedures regarding this program.

912.2 Child and Adult Protective Services

DES/DDD Support Coordinators will report suspicions of abuse and neglect to either Child or Adult Protective services. They must also cooperate during investigations and follow up as required. Specific procedures to follow are outlined in Chapter 2000.

912.3 Vocational Rehabilitation

See Sections 303.2 and 602.3 of this Manual for information regarding Vocational Rehabilitation.

912.4 Department of Education/Local Education Agency

DES/DDD shall coordinate services with the Arizona Department of Education (ADE), Local Education Agency (LEA) under three distinct circumstances:

a. when DES/DDD makes a residential or out-of-home placement for educational purposes (A.R.S. §15-765);

b. when DES/DDD makes a residential placement for other than educational purposes; or

c. when a child receiving early intervention services (day treatment and training) from DES/DDD reaches age 2 1/2, in order to plan for preschool transition.

912.4.1 A.R.S. § 15 Placements

A.R.S. §15-765 allows for residential placements for children for educational reasons. It is not intended to provide long term or permanent residential placements for children. These placements should be for a limited period of time and only for the purpose of accomplishing specific educational goals which promote the child's ability to benefit from a special education program in a less restrictive environment. A.R.S. §15-765 requires that residential placement be made for educational reasons only and not for other issues, such as family matters, that do not justify residential placement for educational reasons.

When residential or out-of-home placement is considered, priority should be given to placement in the home school district so the child can either maintain placement or transition into the district when specific behavioral or educational goals have been met. Exceptions may exist for children

with unusually complex educational needs that cannot be met in the home district, e.g., in remote areas of the State, owever, these reasons must be clearly documented before the placement is approved.

Early coordination of services between the DES/DDD Support Coordinator and the local school District is encouraged. In home support should be provided as early as possible in order to reduce the likelihood that the child will need to be placed in an out-of-home setting. When the public education agency is in the process of developing an Individual Education Plan (IEP), the DES/DDD Support Coordinator should be involved to provide input into the types of services available through DES/DDD and to work with the education agency to ensure that the child is educated in the least restrictive environment appropriate to the child.

When the IEP indicates that out-of-home or 24 hour residential placement for educational purposes may be necessary, the Support Coordinator shall immediately notify the DES/DDD DPM for involvement in the placement process. If placement is to be made out of the DES/DDD District where the child resides, the DES/DDD Support Coordinator/originating DPM must contact the DPM in the receiving DES/DDD District in order to facilitate appropriate placement and services.

When requesting residential services through DES/DDD, pursuant to A.R.S. § 15-765, the following documentation must be provided by the requesting school district to DES/DDD's Support Coordinator, who shall make a copy for the case file and forward the information to the DPM and Central Office Children's Services Coordinator:

a. letter of request for services;

b. parental signature for consent for evaluation and provision of services; and

c. a copy of the IEP which includes:

   1. documentation of least restrictive environment considerations, including the specific reasons why the child cannot be educated in a less restrictive environment;

   2. specific services requested, i.e., residential placement;

   3. length of time for which the placement is being requested, i.e., 6 months, one school year, etc.; and

4. exit criteria (goals which when accomplished will indicate that the child is ready to return home or to the home school district).

Inadequate documentation of the educational reasons for requesting residential placement will result in a delay or denial of the request by the DES/DDD Children's Services Coordinator.

Following approval and placement in an A.R.S. § 15 funded residential placement, the need for placement shall be reviewed every 30 days after placement by the IEP/ISP team. The results of the review shall be documented in the progress notes. Requests for continuation of the placement must be submitted to the Children's Services Coordinator in DES/DDD Central Office for approval by June 15 of each year. Requests for continued placement shall contain the same information and be submitted in the same manner as required for initial placements.

Any proposed change in an A.R.S. § 15-765 placement must be made through the IEP review process. Changes in placement must be consistent with the goals of the child's IEP and recommended by the IEP team. Placements may not be changed for reasons other than those related to educational purposes.

When a child's parents move to a new school district, the District which placed the child must notify the new school district of the placement arrangements.

The new District has the responsibility to review the appropriateness of the placement and use the IEP process to make any recommended changes in the IEP or placement of the child.

When a child is promoted to a high school district, the District which placed the child must treat the promotion as a change of placement and must include the high school district in the IEP review process.

When the IEP team determines that a child needs Extended School Year Services (ESY), no change in the residential placement may be made unless specified in the IEP.

912.4.2 Residential Treatment Center Placement

The DES/DDD Support Coordinator is responsible for notifying the Children's Services Coordinator and the Behavioral Health Program Manager of a proposed or existing recommendation for a child in a Residential Treatment Center (RTC) placement for educational reasons. In addition, the Support Coordinator is responsible for notifying the Children's Services Coordinator of a parent's request for such placement.

Once notified of an eventual or current recommendation for RTC placement for educational purposes, the Children's Services Coordinator

shall contact the appropriate personnel within ADE for purposes of coordination. In addition, in the event the child has a dual diagnosis of behavioral illness and a developmental disability, the Support Coordinator should refer the child to the DES/DDD Medical Director for consideration of review by the DES/DDD Psychiatric Consultant. The Medical Directors of AHCCCS, DHS and DES/DDD may be requested to determine placement and responsible payee(s). Chapter 1400 outlines the process for submission of information to the Medical Director.

The Support Coordinator should submit the following information to the Children's Services Coordinator:

a. a copy of the placement statement from the home school;

b. a copy of the IEP or multidisciplinary conference notes recommending RTC placement for educational reasons; and

c. documentation of parental/guardian approval.

Each May, the Children's Services Coordinator will send out a reminder to the DPMs regarding the status of placements.

912.4.3 Preschool Transition

DES/DDD has entered into an Interagency Service Agreement (ISA) with the ADE to ensure that children reaching their third birthday complete the transition from services provided in early intervention programs funded by DES/DDD to a free appropriate public education with minimum disruption and stress on the child and his/her family.

For each child receiving DES/DDD early intervention services, the DES/DDD Support Coordinator will be responsible for requesting written parental/guardian consent to release information and submitting the following information to the appropriate local education agency (LEA) for each child no later than February 15 of each year:

a. the name of the child residing within the boundaries of the LEA who is being served in an early intervention service;

b. the address and phone number of the child;

c. the birth date of the child;

d. the parents'/guardians' names;

e. the level of severity of the child's disability;

f. the name of the program currently providing services to the child; and

g. the name and phone number of the child's Support Coordinator.

The DES/DDD Support Coordinator shall be responsible to ensure that a Transition Conference is held between the time the child is two years six months and two years nine months old. The purpose of the transition conference is to identify existing assessments, plan for the completion of necessary additional assessments, establish a plan for parent/guardian visitation to the local education agency (LEA) program sites and establish a tentative timeline for the child's transition into the LEA educational system. The Transition Conference shall be documented as a special ISP meeting (see Section 808.5).

Transition Team Membership and Responsibilities:

The transition team shall consist, at minimum, of the child's parent(s)/guardian(s), the DES/DDD Support Coordinator, representative(s) of the current provider of early intervention services and representative(s) of the LEA.

Prior to the transition conference, the DES/DDD Support Coordinator shall provide copies of the assessment information available on the child and a copy of the child's current IFSP/ISP to the LEA for presentation and discussion at the conference. The DES/DDD Support Coordinator is the facilitator at the transition conference and shall document the conference using the ISP Cover Sheet (Appendix 800.A), the Preschool Transition Plan form (Appendix 800.K) and other ISP forms or a narrative as appropriate.

The representative of the child's current program provider is responsible for providing information orally and in writing regarding the child's program and progress within that program.

The LEA representative is responsible for providing information about the educational programs for preschool children available through the district, including eligibility requirements for services. The LEA representative is also responsible for providing the parent(s)/guardian(s) a copy of the parents' rights and procedural safeguards which become effective upon the child's third birthday. The LEA representative is responsible for working with the parent(s)/guardian(s) to plan for visitations to possible preschool options and to establish a tentative timeline for the child's transition into the LEA system. The transition team must address parental consent to release information to the local school district.

Assessment and Eligibility Determination Procedures:

DES/DDD will obtain parental/guardian consent and have the following current (within the last six months) assessments completed or updated and available to the LEA by the time the child is two years six months old:

a. a family assessment, if available/appropriate;

b. developmental history; and

c. a comprehensive developmental assessment;

Following the transition conference, DES/DDD will complete other assessments as determined by the transition team.

The LEA will complete the following assessments prior to the child's entering the LEA preschool but no later than the child's third birthday:

a. norm referenced standardized measures in the areas of suspected disability as identified by the comprehensive developmental assessment;

b. parental/guardian survey measure(s) selected to provide formal parental/guardian input into the assessment process/areas of concern (participation in this component is voluntary on the part of the parent/guardian); and

c. other educational assessments as determined by the transition team.

The LEA is responsible for determining eligibility for special education services via a multidisciplinary evaluation team including the parent(s). If the child is not eligible for special education services, the LEA is responsible for explaining the results of the evaluation to the parents/guardians and the child's Support Coordinator and for providing notice of procedural safeguards.

If a child is not eligible to receive special education services, the DES/DDD Support Coordinator must immediately complete a redetermination of eligibility for continued DES/DDD services as outlined in Chapter 500.

IEP/IFSP Conference:

If the child is eligible for special education, the LEA is responsible for conducting the IEP/IFSP conference, obtaining appropriate parental/guardian consent and offering appropriate services to the child.

It is the responsibility of the DES/DDD Support Coordinator (or a representative) to attend the IEP/IFSP conference. The Support Coordinator will present information about non-educational services available through DES/DDD once the responsibility for educational services has been transferred to the LEA. The Support Coordinator will also present the requirements for continuing eligibility for DES/DDD and ALTCS once the child reaches his/her sixth birthday.

It is the responsibility of the provider of the child's current early intervention program to attend the IEP/IFSP Conference and to offer insights into the needs of the child and provide input regarding appropriate programming.

Continuation of DES/DDD Early Intervention Services After the Child's Third Birthday:

If it is determined by the IEP/IFSP team that the most appropriate educational environment for a child is to be maintained in the early intervention model currently provided through DES/DDD, the child may stay in that program until the next logical school transition period or until a change in program or services is necessary, **whichever comes first**.

For children who turn three years of age before September 1, the logical transition period is the first day of that school year. For children who turn three between September 1 and December 1, the logical transition period is either the first day of that school year (if permitted by LEA policy) or the first school day following the Thanksgiving holiday. For children who turn three between December 2 and December 31, the logical transition period is either within ninety days prior to the child's third birthday (if permitted by LEA policy) or the first school day following the Christmas holiday. For children who turn three after December 31 of the school year, the next logical transition period is the beginning of the next school year (State statute permits, but does not require, LEAs to admit preschool children with disabilities up to 90 days prior to their third birthday). The Governing Board of each LEA is responsible for establishing policy regarding whether or not they will admit children prior to their third birthday.

Once the next logical transition period arrives or the IEP/IFSP team determines that the most appropriate placement for a child requires a change in program or services **which ever occurs first**, the LEA assumes responsibility for providing or paying for the provision of services. If, at any time following the child's third birthday, the parent requests the LEA to assume responsibility for a free appropriate public education the LEA will do so.

912.5 Residential Placement for Other than Educational Purposes

On occasion, people with developmental disabilities under the age of 18 may need out-of-home residential placement in a DES/DDD contracted setting. While the majority of these children will be placed after having been adjudicated dependent wards of the court or as a result of placement in voluntary foster care as provided by A.R.S. §8-546.05, there will be children who need out-of-home placement for reasons other than those leading to juvenile court involvement.

These reasons relate directly to the child's disability and the genuine inability of the parents to meet the child's needs in the family home, even with the provision of available supports by DES/DDD.

Pursuant to A.R.S. §36-552(C); §36-558(A) and §36-560(B), the provision of State funded services is subject to available appropriations. This necessitates formal consideration and strict budget control by the Assistant Director of all requests for voluntary out-of-home placement for children under the age of 18. Foster Care funds may not be used for voluntary out-of-home placements.

Any consideration of a voluntary out-of-home placement recommendation or request will be decided on a case by case basis by the Assistant Director, contingent upon available funding. Strong factual evidence must show that the placement is clearly in the child's best interest and that the following criteria have been tried or met:

a. following specified procedures, the parents and other members of a school district IEP team, in consultation with DES/DDD, have determined that the child requires a time limited out-of-home placement in order to receive an appropriate special education (A.R.S. § 15-765); or

b. the child is eligible for and receiving Title XIX behavioral health services and a multidisciplinary team, in consultation with DES/DDD, and with the approval of the parents, has determined that the child requires a DHS contracted setting, e.g., a residential treatment center or a therapeutic group home, as a result of behavioral health problems; or

c. the parents and other members of the ISP team determine the child needs short or long term out-of-home placement after (1), (2) and (3) have been tried or ruled out and if (4) is true:

    1. reasonable efforts by DES/DDD have been made to provide in-home supports and there is documentation that the parents have actively participated and that the supports have not been successful in meeting the child's needs;

    2. parents have explored the option of placement with a relative, with the provision of available supports from DES/DDD and it has been ruled out as a viable option;

    3. alternatives such as part time out-of-home placements have been created and tried without success;

    4. services needed by the child cannot be provided in the home community.

Based upon recommendations from the ISP team, verification that the above criteria have been met or have been determined to be inappropriate and certification as to availability of funds, the DPM may recommend the placement to the Assistant Director who must approve the placement.

Responsibilities of the Parents/Guardians:

a. parents/guardians must be in agreement with out-of-home placement;

b. parents shall visit and approve the proposed placement prior to a decision being made;

b. parents shall sign an agreement to contribute financially to the placement. The amount of parental contribution will be determined on a sliding fee scale based on income. If the child receives SSI, the contribution to the residential costs will equal 70% of the monthly SSI benefit, in addition to the parental assessment. In such cases, the monthly SSI benefit will not be included in the family income when determining the amount of parental assessment.

   In addition, parents will provide those items, such as clothing and other personal expenses, which typically are not included in the rate paid to providers of residential services;

d. parents shall visit the child and/or take the child home for visits on a regularly scheduled basis. The frequency of the planned visits shall be determined by the parents and the ISP team and will be documented in the ISP;

e. parents will continue to actively participate in the medical care of the child and in the ISP and IEP processes; and

f. parents may request a gradual transition into the placement.

Responsibilities of DES/DDD:

a. prior to a placement being made, DES/DDD shall create agreements with the provider for the parents and siblings to visit on a regularly scheduled, frequent basis as determined by the ISP team;

b. children should be raised within families. Consequently, DES/DDD shall make reasonable efforts to place the child in a setting appropriate for the individual child that is as homelike as possible and in as close proximity to the family as feasible. This home must be prior approved by the family;

c. upon parent request, DES/DDD will plan for and arrange, in coordination with the ISP team, a gradual transition into the out-of-home placement;

d. the DES/DDD Support Coordinator shall visit and assess the appropriateness of the out-of-home placement prior to the child being placed there;

e. the DES/DDD Support Coordinator shall visit the child in the residential placement within 10 days of placement and at least quarterly thereafter. This is the minimum visitation frequency, even if ALTCS guidelines allow for less frequent service plan reviews;

f. the need for continued out-of-home placement will be reviewed and documented during the ALTCS service plan reviews and semi-annually at the time of the ISP review;

g. since the ultimate goal is for the child to return to the family when possible, the DPM shall review and report to the Assistant Director the status of each child in out-of-home placement at least every six months. The review shall ensure that the child's needs are being met in the placement, that the need for placement still exists, that circumstances still meet the placement criteria, that both DES/DDD and the parents have met their responsibilities and that the child has not been abandoned as defined in A.R.S. § 8-546; and

h. DES/DDD, in coordination with the ISP team, will plan for the child's return to the natural home as circumstances permit.

In the event an appropriate placement cannot be made within the boundaries of the child's current school district, the DES/DDD Support Coordinator should consider the ability of the receiving school district to meet the child's educational needs when planning for the residential placement. In such instances, the Support Coordinator shall immediately contact the Special Education Director of the school district in which placement is being considered. As soon as possible, the Support Coordinator shall provide the following information to the Special Education Director:

a. target date the child will establish or change residence;

b. copy of court order(s) establishing dependency, legal guardianship or parent surrogate, if appropriate; and

c. all relevant psychological, educational and medical records including the most recent psychoeducational report; relevant social and developmental history if not included in the psychoeducational evaluation; immunization record; medical certification within the last 3 years of a physical disability, visual impairment or hearing impairment, if

appropriate, and current educational records (IEP, placement statement, therapy reports/evaluations). If a psychoeducational report does not exist, the school district is responsible for completing the evaluation.

Within 5 days of receipt of this information, the Special Education Director should contact the DES/DDD Support Coordinator to set a date for a multidisciplinary conference and initiate the evaluation and IEP processes for special education placement. If a parent, legal guardian or legally appointed surrogate parent is not available to consent to evaluation and special education placement, the DES/DDD Support Coordinator shall work cooperatively with the LEA's Special Education Director to obtain appointment of a surrogate parent.

The DES/DDD Support Coordinator shall participate in IEP meetings for children in residential placements operated by or financially supported by DES/DDD, but may not legally consent to special education placement.

912.6 Children's Rehabilitative Services (CRS)

CRS provides rehabilitative medical care to children with special health care needs. To be eligible for services, the individual must be an Arizona resident under 21 years of age and have a physical handicap or a condition that is potentially handicapping which has the potential for functional improvement through medical, surgical or therapeutic modalities. There are also financial criteria established by DHS. All children enrolled in ALTCS, AHCCCS or CMDP meet CRS financial eligibility criteria.

Early referral is encouraged to assure the most successful results. To access services, a referral can be made by the PCP, Support Coordinator or the individual or family. At the time of referral, it is important to note if the individual is a member of ALTCS, AHCCCS, CMDP or has made application to these programs. All individuals must be reviewed by the clinical director at the appropriate CRS site (Phoenix, Tucson, Flagstaff or Yuma). The clinical director will make the determination as to the appropriate clinic or clinics for service. To refer an individual to CRS, complete the Pediatric History and Referral Form (FW-206) and send it to the nearest CRS office.

CRS is not an acute health care or primary care provider. It provides medical and related services for the purpose of curing or significantly impacting the CRS covered condition. Each individual is expected to have a PCP who will provide primary health care.

Applicants who are deemed financially eligible for CRS authorized services at the lowest payment category include the following:

a. individuals eligible and enrolled in a Medicaid or non-Medicaid AHCCCS Health Plan or AHCCCS program contractor;

b. wards of the State or of the court;

c. DES/CMDP foster children; or

d. DES adoption subsidy children (until adoption is complete).

Information necessary to establish evidence of the criteria in the above mentioned items shall be verified by CRS.

To qualify medically for CRS, the individual case shall be evaluated in a CRS pediatric screening clinic or specialty clinic by a member of the CRS medical professional staff. The physician or his/her designee determines if the individual has a handicapping or potentially handicapping condition that is eligible for treatment by CRS.

CRS has delegated the responsibility for conducting financial interviews with CRS applicants to determine financial eligibility for the CRS Program to the DES Division of Benefits and Medical Eligibility which is out-stationed at CRS offices.

Services provided by CRS include:

a. hospitalization only at CRS contracted provider sites for CRS covered procedures;

b. home health care limited to post-hospitalization recovery periods not to exceed 30 days. Services include nursing, therapies, equipment and medications. CRS contracted health care providers have the option to provide home health care in lieu of hospitalization if the CRS attending physician determines it to be medically appropriate;

c. clinical services provided at any CRS sponsored clinic, but appointments must be authorized by a CRS physician;

d. family support services including psychosocial services for the purpose of supporting families with children with special health care needs. Social work support is provided on an in and out patient model only. Social workers are available at all sites to assist individuals/families with issues related to the rehabilitative medical care. Psychological services are available for short term crisis intervention and assessment (limited to 3 visits). Educational coordination is available to assist families with coordination with the public schools;

e. medications ordered by CRS physicians appropriate to the treatment of the CRS condition;

f. formula and special diets for individuals with Phenylketonuria;

g. treatments for individuals with Sickle Cell anemia;

h. therapies for the purpose of treating the CRS covered condition. Priorities for the provision of therapies have been established by CRS; and

i. equipment for the purpose of short-term rehabilitative care. All equipment must be related directly to the care of the CRS covered condition; personal care and adaptive equipment are not covered. CRS will provide and repair wheelchairs as well as ambulation assistive devices such as crutches, canes and walkers. CRS does not provide power wheelchairs or adaptive power switches for wheelchairs.